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ORIGINAL PAPER

Rethinking Crisis as Expected: Stakeholder Leadership in Navigating Ethical Dilemmas and Avoiding Polycrises

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Abstract
Extant literature on crises and crisis management is predominantly based on the assumption that crises are unexpected events. However, in the past two decades, we have noticed crises arrive continually, and experts have warned that we are prone to a range of crises, including climate change, migration, industrial incidents, and other crises of financial, cyber, reputational, social, and political nature. These recurring crises and warnings mean considering all crises as unexpected events is illusory and can lead organizations into polycrises, or systems of multiple, interconnected crises. We conducted a 17-month longitudinal case study on a nonprofit health care organization that faced the COVID-19 pandemic. We found that organizational leadership considered the crisis as an expected event, which helped the organization avoid purposeful ignorance and unintentional actions that could exacerbate a crisis or even develop into a polycrisis. Our study contributes to literature in three ways. First, it illustrates the dimensions of expected crises and their underlying ethical dilemmas. Second, we explain that organization's purpose has a crucial role in helping leadership navigate ethical dilemmas during a crisis. Third, we identify three characteristics of stakeholder leadership: enfranchising new leaders, facilitation, and sharing in operational work. Our findings and framework offer three implications: (1) embrace an expected crisis, (2) emphasize purpose to navigate ethical dilemmas, and (3) adopt stakeholder leadership instead of centralized leadership.

Keywords Expected crises · Ethical dilemmas · Purpose · Stakeholder leadership · Polycrisis

Introduction

The COVID-19 crisis was a deadly event that shook people and organizations around the world. The pandemic was particularly devastating for health care organizations due to their central role in dealing with the crisis and the sudden rise in seriously ill patients. Hospitals were forced to handle the rising number of COVID-19 patients while giving care to regular patients and managing staff, their fears, and resource shortages (Li et al., 2023). Therefore, hospital leadership needed to deal with clinical, operational, financial, coordination, and psychological challenges.

Due to these challenges and the catastrophe COVID-19 caused for medical professionals managing the crisis, health care leaders, particularly in developing and underdeveloped countries, faced several ethical dilemmas, such as whether to halt hospital operations to save employees, whether to open hospital doors to save patients, and how to save both hospital employees and patients. Being confronted with such ethical dilemmas often surprises decision-makers. Indeed, the extant literature mainly considers crises to be

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unexpected events (Buchanan and Denyer, 2013), and immediate decisions in crisis situations tend to neglect ethical considerations.

Organizations tend to ignore signals of ensuing crises, which prevents them from making the right ethical choices during those crises, thereby leading to polycrises—events that capture overlapping and interconnected crises (Henig & Knight, 2023). For instance, Nestlé S.A. (Nestlé) ignored a 2015 Maggi Noodles recall prompted by safety concerns in India, a choice which cost the company $55 million, excluding reputational costs (Menghwar & Daood, 2021). Nestlé's choice to ignore the initial signals became a product crisis, a brand reputation crisis, and a financial crisis; in other words, it grew into a multipart crisis, or a polycrisis. Similarly, the denial of anthropogenic climate change by both leaders and the public despite ample warnings is another illustrative case of ignoring crises—in this case that could come due to changes in climate (Prasad, 2019). In the case of this study, multiple world leaders' ignorance of the World Health Organization's (WHO's) scientific information about the COVID-19 crisis (Nichols, 2020) resulted in the deaths of millions of people and led entire countries into polycrises. Later, other factors such as a lack of information available at the time regarding the disease, its symptoms, and appropriate treatment led to polycrises.

In the wake of a crisis, the role of leadership is crucial in averting further crises or preventing crises from cascading into polycrises. There are two schools of thought on a leader's role in such scenarios. The first school argues that a leader should prevent crises from occurring, make fast decisions when they do occur, and lead others out of a crisis (James et al., 2011; Wu et al., 2021). Such thinking usually highlights the importance of a focal leader (Friedrich et al., 2016). Another school argues that involving diverse people in making decisions about ethical dilemmas serves the common good (Graham, 1995; Ilori et al., 2024). However, involving multiple people in decision-making during a crisis can slow down the process of crisis management, which could increase a crisis' negative impact. For instance, Walumbwa et al. (2014) suggest that in crises, every moment counts; therefore, leaders need to move fast to control a crisis. These conflicting views make it unclear how leadership should organize in the wake of the crisis. Therefore, studying the complexities leaders face when managing crises will enhance our understanding of a leader's role in a crisis. To do so, we conducted a longitudinal case study on a health care organization, while a crisis was unfolding to understand how can organizational leadership address ethical dilemmas and organize to achieve organizational purpose?.

Our findings contribute to literature in three ways. First, we demonstrate why crises could be expected events, and organizational leaders should frame them as such to avoid purposeful ignorance and unintentional actions that can further enhance the severity of a crisis or a polycrisis. Framing crises as expected can assist leadership or other actors in forecasting a crisis and encourage them to prepare and organize in anticipation rather than in crisis aftermath. Second, we shed light on how revisiting the fundamental purpose of organizational existence can help manage the ethical dilemmas that accompany expected crises. Third, building on stakeholder theory, we present three characteristics of stakeholder leadership during a crisis: enfranchising new leaders, sharing operational work, and facilitation. These characteristics are crucial in inspiring co-leaders and achieving organizational purpose during a crisis situation. Building on this, stakeholder leadership can be defined as two or more leaders sharing operational as well as strategic work and facilitating to fulfill the interests of internal and external stakeholders. These findings encapsulate three practical managerial implications: (1) embrace expected crises, (2) emphasize purpose to help resolve ethical dilemmas, and (3) adopt stakeholder leadership instead of centralized leadership.

Theoretical Background

An organizational crisis is defined as "an event perceived by managers and stakeholders to be highly salient, unexpected, and potentially disruptive" (Bundy et al., 2017, p. 1663). Organizations can confront a diverse range of crises for multiple internal and external reasons. Hence, crises are difficult to capture in one definition or category, or to view through one theoretical lens (James et al., 2011). Bundy and colleagues integrated the past literature by organizing it into two broader perspectives: internal and external (Bundy et al., 2017). The internal perspective centers on the organizational dynamics of managing a crisis, and the external perspective focuses on dealing with external stakeholders. The literature on both perspectives has evolved independently, but one common theme is that the role of leadership is crucial in managing ethical dilemmas and the negative effects of crises (Bundy et al., 2017; James et al., 2011; Weick, 1993; Williams et al., 2017).

Leadership in a Crisis Situation

A vast amount of research has been done on leadership (Ford et al., 2023; James et al., 2011; Pearce et al., 2023), which can be categorized into two types: unitary leadership and stakeholder leadership. The former emphasizes the single-leader style and its effectiveness in crisis management. The latter considers leadership as a social process involving multiple people who take moral responsibility and engage with other leaders to achieve a shared purpose in the face of uncertainty (Denis et al., 2012; Freeman et al., 2007).

We use the term *stakeholder leadership* because of its focus on relationships with multiple leaders and stakeholders. Advocates of stakeholder leadership focus on the enacted processes of leadership (multiple leaders) instead of on one lone leader (Schneider, 2002). Scholars have used different labels for stakeholder leadership—for example, responsible leadership (Doh & Quigley, 2014; Maak & Pless, 2006), ethical leadership (Freeman et al., 2007), and servant leadership (Lemoine et al., 2021). However, they have uniform views on the characteristics and priorities of leadership: moral values and sustaining good relationships (Freeman et al., 2007; Maak & Pless, 2006; Menghwar & Freeman, 2023). For example, Maak and Pless (2006) argue that "leadership is a social-relational and ethical phenomenon that occurs in interaction between a leader and a broader group of followers, inside and outside the organization" (112). Similarly, building on stakeholder theory literature, Schneider (2002) describes the stakeholder model of organizational leadership as leadership that relies on nonhierarchical relationships, several types of authority, and the decoupling of leadership functions and managerial roles.

Past research has enhanced our understanding of how a stakeholder approach to different forms of leadership can both ensure the safety of other leaders and manage stakeholders. For example, a study on health care leaders working in intensive care units found that a proactive approach from physicians or senior doctors is important in ensuring the psychological safety of lower-level team members (Nembhard & Edmondson, 2006). However, scholars have not explained how stakeholder leadership manages ethical dilemmas, especially in situations where leaders have overlapping roles and authority during a crisis (Boin et al., 2005; Nesse, 2017). Studying stakeholder leadership in the wake of a crisis is crucial because crises pose unique ethical challenges; such research would thus provide much needed conceptual and practical depth about the way leadership navigates.

Ethical Dilemmas for Stakeholder Leadership in Crisis Situations

The *Stanford Encyclopedia of Philosophy* considers a situation to be an ethical dilemma when an "agent regards herself as having moral reasons to do each of two actions, but doing both actions is not possible" (Stanford Encyclopedia of Philosophy, 2024). The words *ethical dilemma* and *moral dilemma* are often used interchangeably. Ethical dilemmas pose a challenge to leaders' behavior, and universal principles are considered useful in resolving ethical conflicts and dilemmas (Graham, 1995). For example, consider an empirical study on a product harm crisis (PHC), an event in which a firm's product is reported as flawed and has failed to meet safety standards (Zhang et al., 2021). Leaders in this situation face an ethical dilemma: Engage in earnings management to neutralize the negative impact of the PHC or accept the negative financial consequences in financial statements. The study found that when faced with a PHC, some managers engage in unethical and fraudulent financial reporting practices (Zhang et al., 2021).

Past research has shown that behavior in moments of ethical conflicts is a testament to leaders' overall ethical behavior. Stressful situations present additional challenges to leadership because of their dual effect on leadership's ethical actions and recognition of ethical dilemmas (Selart & Johansen, 2011). Similarly, Snyder and colleagues state that in crisis situations, leaders' ethical values are revealed more clearly (Snyder et al., 2006).

The health care context presents additional challenges to leadership; the critical professional role of senior doctors gives hierarchical dominance to medical specialists and limits the distribution of leadership roles and power (Currie and Lockett, 2011). Due to this power imbalance in health care organizations, leadership has little authority to decide what is ethically good. Leaders must deal with conflicting stakeholder interests (i.e., those of doctors and patients) as well as strike a delicate balance between patient rights and doctors' professional duties (Ilori et al., 2024).

Furthermore, research has shown that involving different people when making decisions about ethical dilemmas serves the common good (Graham, 1995; Ilori et al., 2024). But doing so can also slow down the decision-making process, especially in crisis situations that require a rapid response. Health crises further aggravate the involvement of multiple leaders in managing crises. In the case of COVID-19, this was due to high transmissibility, frequent exposure, and a lack of effective treatments at the time.

Health care leadership during the pandemic confronted an ethical dilemma: Either exclude other doctors from leadership roles or include team members from diverse backgrounds—but risk threatening their lives. Hospital leadership and senior management needed to find a way to address the ethical dilemma (employees' safety versus inclusion). Stakeholder leadership is about relationships, but managing those relationships during a potentially life-threatening crisis is challenging. Therefore, deeper investigation is necessary into how stakeholder leadership addresses ethical dilemmas that emerge during crisis management. This research is important for understanding the functioning of stakeholder leadership that can guide leaders and managers in dealing with ethical dilemmas in the wake of a crisis.

Research Methodology

Case Setting

We performed a longitudinal study on the Indus Hospital (TIH), which was established by four doctors in Karachi, Pakistan, in 2008. TIH is a nonprofit organization whose mission is to provide quality health care to underprivileged people at zero cost. The main hospital is in Karachi, and there are nine other branch hospitals across Pakistan (Indus Hospital, 2020). The hospital has no cash counter and does not charge any fees to patients; however, it raises donations from individuals, corporations, the government of Pakistan, and other funding agencies.

Why Case Study Research?

Conducting a real-time study on crisis management, specifically on the role of leadership during a crisis, is challenging. First, crises are considered unexpected events, so planning a study is difficult. Second, crises adversely affect performance; thus, organizations avoid sharing information about crises or access to people who are managing crises (James et al., 2011). However, in our case, one of TIH's founders showed interest in recording how TIH would manage a crisis, and the first author benefited from this opportunity to investigate. Subsequently, the coauthors found that there were no real-time longitudinal studies on leadership in crisis management (Wu et al., 2021); hence, research was needed. Crisis scholars believe that case study research is appropriate for studying a crisis that is unfolding or going through stages such as pre-crisis, crisis, and post-crisis (Collins et al., 2022). Several review papers on crisis and crisis leadership found that past literature lacks rigorous and reliable qualitative studies (Bundy et al., 2017; Wu et al., 2021). Therefore, scholars have repeatedly called for longitudinal qualitative studies on understanding crisis, the characteristics of crisis leaders, and how leaders manage stakeholders in a crisis (Bundy et al., 2017; Collins et al., 2022; Wu et al., 2021). Thus, we specifically chose the case study method for our research.

Contextual Appropriateness

Besides those general reasons, this hospital was expecting a crisis; therefore, leadership was fearful, under pressure, and the primary force for managing the crisis. The hospital's actions before and during the crisis were thus well-suited for studying the role of leadership in a crisis. Another potentially illuminating characteristic of this particular hospital site was its under-resourced context. Hospitals in general were under-resourced during the COVID-19 crisis due to supply chain and industry disruptions and import restrictions on health equipment. Furthermore, hospitals in underdeveloped countries are often highly under-resourced due to large populations and poor health facilities. Some health experts had forecasted that underdeveloped countries might face a greater crisis that could be particularly harmful to staff members; thus, leadership needed to deal with additional ethical dilemmas emerging from these forecasts. Overall, TIH provided an especially appropriate context for studying how organizational leadership addresses ethical dilemmas and organizes to achieve an organizational purpose amid a crisis.

Data Collection

This paper is part of a larger research agenda that started in 2019, the initial focus of which was to investigate how the charity hospital achieved exponential growth in an under-resourced context. This study is based on a longitudinal case study that covered a period of 17 months. The first round of data collection started on April 3, 2020, with open interviews in the early weeks of the pandemic. The principal researcher first coded the open interviews, prepared the interview protocol, and then conducted semi-structured interviews. The second round of data collection using these semi-structured interviews started on April 25, 2020, and continued to January 4, 2021. We implemented the longitudinal study covering the second wave of the pandemic because we thought it might have been luck that led to TIH's survival after the first wave. We questioned whether we needed to wait and analyze the material in more detail, and therefore we waited to see what changes the hospital made in the second wave. Finally, the third round of data collection, through semi-structured interviews, started in May 2021 and ended August 30, 2021. Although we had sufficient data from the first two rounds, we undertook a third round of data collection because hospitals in India that had survived the first wave of the pandemic collapsed quickly during the April 2021's wave (Seervai & Shah, 2021).

India and Pakistan were one country before their partition in 1947; both have similar cultures, demographics, and health dynamics. Experts were expecting that hospitals would collapse in Pakistan too, and we wanted to understand how Pakistani hospitals would manage a crisis under this new fear. We conducted 47 interviews (6 open and 41 semi-structured) with 33 people during the crisis period (Table 1). We describe our three modes of data collection in detail in the following section.

Discussions and Open Interviews

We initiated data collection with open interviews. An open interview is a loosely guided or less structured interview

Table 1 Overview of participant's interviews (all three rounds)

Role/Department	Round 1 Open Interview (OI)	Round 2 Semi-Structured Interview (SSI)	Round 3 Semi-Structured Interviews (SSI = 2)
Founders (Top Leadership)	2	2	
COVID-19, Lead Group and Director Branch Hospital	4	4	
Corona Task Force	0	8	8
Administration and Quality Control Department	0	4	
Medical Residents	0	3	
Nurses	0	3	
Department of Supply Chain Staff	0	4	
Department of Pathology and Laboratory Staff	0	5	
Round Total	**6**	**33**	**8**
Total	**47**		

for the purpose of exploring topics (Charmaz, 2006). We started the open interviews before the peak of the crisis in Pakistan to understand the nature of planning and the leadership team's expectations for coping with a coming crisis that had caused trouble in developed countries. We chose open interviews because we wanted to conduct an inductive study. We were also unfamiliar with the crisis literature, so we were not sure which aspects of this case had been explored in the literature and would be the most interesting to study. We were fascinated in particular that the hospital had managed to provide free quality health care to low-income people for 15 years.

Moreover, despite their lack of resources during COVID-19, TIH decided to provide health care services while many private hospitals[1] in Pakistan closed their doors to COVID-19 patients. We believed that TIH's founders and higher management had made the risky decision to stay open and provide health care service. Therefore, at first, we conducted open interviews (n = 6) with the founders and those working in different leadership positions in crisis management: the chairman and founder, the executive director and founder, TIH's director for branch hospitals, and three members of the COVID-19 lead group (the managing director of the main hospital, the chair of medicine & allied services, and the chair of emergency services).

We initiated the open interviews with a discussion of the participants' profiles and their roles in the present crisis. Rather than having a list of specific questions, we asked context-establishing questions that enabled us to understand the hospital's functions; for example, who was responsible for decision-making, what their functions were, and how the reporting system worked. Other broader questions included: "How are leaders analyzing the information regarding the crisis?" and "How is hospital leadership raising funds?".

Semi-Structured Interviews

In the second phase, we performed semi-structured interviews (n = 41) with people who had a crucial role in managing the pandemic crisis.

For example, in our open interview with two founders, we discovered that the hospital was established collectively by four doctors who still worked in key positions and were actively involved in crisis management; we did a semi-structured interview with the remaining two founders (n = 2). We also interviewed senior consultants, consultants, and doctors (n = 8) who were working in the COVID-19 ward and performing technical jobs. These people were part of the Corona task force designed by the medical director and comprised of people with expertise in emergency work and infectious disease. We also interviewed four people (n = 4) working in the administration and quality control department.

As suggested by Gibbert and Ruigrok (2010), to enhance the credibility of this research, we interviewed lower-level employees of leadership (followers or subordinates); our aim was to learn about their opinions, how top management supported them, and their role in the crisis situation. In addition, interviewees included medical residents (n = 3) and nurses

[1] Private health care systems are common in developing countries. One report by the World Bank found that in low-income countries, the private health sector is the major source of primary health care (Coarasa and Das, 2015). In another survey of 70 underdeveloped and developing countries between the period of 1990–2013, in the poorest areas, 40% of the population sought private care, and this percentage was over 50% for the treatment of childhood illnesses (Grépin, 2015). This percentage is lower in well-developed countries where around 29% of people go for private health care in Australia, Canada, and around 15% in France, Germany, and the Netherlands (Canadian Medical Association, 2024).

(n = 3) who dealt with the crisis. We also interviewed lower-ranked employees working in the supply chain department (n = 4) because there was a shortage of personal protective equipment (PPE) around the world, and nurses were complaining that hospital management had failed to secure enough PPE for its employees, increasing employees' risk of becoming infected while treating patients (Iheduru-Anderson, 2021). Therefore, it was essential for us to understand how the leadership of this hospital managed its PPE supply. Another department chosen for interviews was pathology and laboratory medicines, due to its critical role in testing COVID-19 patients and delivering results on time. We interviewed the chair of pathology services (clinical laboratories) and their subordinates (n = 5).

Fourteen participants were interviewed twice. This was done for multiple reasons. Primarily, because we had already conducted the first open-ended interviews with two founders and four senior management people who had a critical role in the COVID-19 response, we wanted to probe further into the dialogue of the first interviews to better understand the interviewees' opinions. With eight people, we did semi-structured interviews twice; these were the people who were part of the Corona task force designed for the execution of policies and running the ward. We interviewed them a second time because of their critical leadership roles. Second, as we analyzed the data, we noticed interesting or puzzling points. For example, questions arose related to how multiple leaders were involved in leadership roles and the purposes of those roles in dealing with ethical dilemmas. As these eight people were performing key leadership functions and our focus was directed to the characteristics of leadership and ways of managing ethical dilemmas, we interviewed them again to get a deeper understanding of their views.

The first author conducted all the interviews, collected notes, and personally visited the COVID-19 ward. All interviews were transcribed. The average duration of interviews was around one hour; however, some open interviews took longer—some lasted as long as 1 h 40 min. The interview protocol for the semi-structured interviews (Appendix A, attached as supplementary material) was prepared from the themes of the open interviews. Crisis scholars have questioned the quality and reliability of existing studies published on crisis leadership (for details, see Collins et al., 2022). To enhance credibility, we collected data from secondary sources to remove biases, overcome limitations, and enhance the study's rigor.

Secondary Data

We analyzed 230 pages of secondary data, including email correspondence among leadership and staff and performance reports. We analyzed these secondary data to triangulate with the primary data. For example, in an interview, the medical director and one founder claimed that we had excluded the chief operating officer's (COO's) role in generating a faster response to the crisis. In order to understand how this had happened and the COO's reaction, we asked for a record of the email conversation. Moreover, to triangulate the claims about the hospital's performance, we used secondary data such as reports submitted to the WHO. Table 2 illustrates the protocol we developed for analyzing the secondary data and for triangulation purposes. As per Farmer et al.'s (2006) suggestion, we ensured triangulation in numerous ways.

Data and Theoretical Saturation

We stopped conducting further interviews after we reached data saturation, a threshold we determined when the last three interviews displayed a large number of similarities and when we failed to gather new insights or themes from the data.

Data Analysis

The data analysis process comprised three major steps.

Step 1: Creating First-Order Codes and Initial Categories

We started with open coding to understand the phenomenon (Strauss and Corbin, 1998). The primary author analyzed the data. Through a detailed analysis, we aimed to answer questions about how hospital leadership analyzed the crisis, what actions the leadership took to reduce the negative impact of the crisis, and how the leadership engaged in resolving ethical dilemmas. What especially caught our attention

Table 2 Triangulation protocol used for collecting and analyzing secondary data

Steps	Description
Triangulation Protocol Research Questions	What was the leader's role and characteristics? How did they make decisions? How has the leadership interpreted and managed ethical dilemmas?
Collecting data or Sorting	We collected performance reports, minutes of meetings, and email exchanges between the leadership and its team
Convergence coding	We highlighted the main themes and then convergence was classified under three levels: complete, partial convergence, and zero convergence

was how multiple leaders (senior and new) were working together and focusing on social purpose in a stressful crisis situation without fighting. After we identified this main puzzle, two authors reanalyzed the transcriptions separately and prepared summary sheets with a focus on leadership and resource collection. This process was to track common themes in the data, which were discussed and compared. The first author also shared the summary sheets with senior colleagues requesting their analysis for comparison purposes.

Next, we classified the pieces of data, labeling each with a particular code. For example, in the open interviews, one founder said, "We will protect the nation," so we labeled this with the code "pursuing a social purpose." We continued in this fashion, which resulted in a vast number of codes. We found several other codes, such as "decentralized structure," "the experience of crisis," and "moving to telehospital services for elective units." These were interesting categories, but not highly relevant or theoretically rich; therefore, we dropped these categories and focused more on leadership's role in managing ethical dilemmas.

For example, in one interview, the supply chain director said, "In the February meeting, we expected a lethal situation," and we labeled this code "fear of expected crisis." We compared this with secondary data from the contents of meeting minutes. Based on similarities and differences among codes, we formed categories. For example, initial codes regarding collaboration were merged under the category of "stakeholder involvement strategy." Moreover, data were reviewed multiple times to reorganize the categories. In some cases, we revised the category if it did not fit well into the previous category; for instance, the category "collective sensemaking" was more about decision-making by multiple leaders—therefore, we revised it accordingly.

We moved iteratively between this study's data and the relevant literature to develop the categories. Therefore, ostensibly, we used an abductive approach to reveal surprising findings in relation to the published literature (Timmermans & Tavory, 2012). Initially, we were unfamiliar with the literature on crisis management, so after coding the open interviews, we explored the literature to reevaluate the data. We found a voluminous number of categories emerging from the data that revolved around specific themes such as "distributing the lead role to different people," "shared work—operational and strategic work," and "purpose."

We iteratively moved back and forth from the data to the literature on crisis leadership. During this process, we found that our participants highlighted the role of multiple leaders. Building on this insight, we compared the leadership characteristics and roles explained in the literature. We found a few unexpected results in light of the extant literature on crisis leadership, mainly charisma and the way one leader inspires followers during a crisis. However, our analysis showed that the organization emphasized a team of leaders instead of one leader, and that leaders who were doing operational work and giving power to experts (despite also being medical experts themselves) inspired others. This repetitive and iterative analysis was critical in developing categories, which included multiple leaders, shared work, and organizational purpose, to list a few. When conducting the data analysis, we examined transcripts, summary sheets, and discussions with people and the authoring team (Charmaz, 2006).

Step 2: Integrating Subcategories and Creating Theoretical Categories

Here, our goal was to connect and integrate related subcategories into broader categories, which we achieved by looking at interrelationships. For example, two prominent codes were "delegating power" and "groups of senior leaders performing operational jobs." We merged these codes under one category, "characteristics of stakeholder leadership." As another example, our data analysis consistently showed that the hospital was not dependent on a single leader, but rather on a group of leaders who were performing multiple functions. This finding contrasted with the leadership literature, which usually highlighted the role of a single leader in managing a crisis. A well-cited example is New York City Mayor Rudy Giuliani's role in managing the 9/11 crisis, which led *TIME* magazine to name him its 2001 "Person of the Year" (Gibbs, 2001). Aside from this, the literature on plural leadership was naïve or silent on the characteristics of these leaders in crises. This gap in the literature helped us explore and describe the characteristics of multiple leaders. We integrated the subcategories ("groups of leaders performing operational jobs") and developed one abstract theoretical category that we labeled "stakeholder leadership." In other words, we moved from open to axial coding (Strauss & Corbin, 1998).

Step 3: Aggregating Theoretical Categories and Developing a Theory

In this step, we searched for multiple connecting categories to be merged into a process model as the crisis unfolded over time (Langley, 1999). We created 14 different models, received opinions from our participants, and presented our findings at several conferences and seminars. Collecting and implementing feedback, we agreed upon the theoretical categories and formed the current process framework, which starts with an expected crisis that is fearful and creates chaos, posing two ethical dilemmas (to close operation or protect the community and centralized leader versus stakeholder leadership). Then we illustrated the three characteristics of stakeholder leadership and its impact on achieving social purpose.

Findings

The first wave of the COVID-19 crisis in Pakistan started in late May 2020, when the number of patients started increasing and images of the havoc caused by the pandemic in developing countries began circulating. TIH started preparing earlier for how its hospitals would function during the crisis. Our findings begin by explaining the hospital's approach to considering the crisis an expected event, thereby empowering TIH to use its organizational purpose to confront ethical dilemmas. Leadership also built relationships by sharing power, roles, and responsibilities with new leaders while still overseeing and supporting their work. Using this style, those higher-ups facilitated new leaders in a collaborative way (debating and decision-making). Moreover, this overall organizational approach had a vital role in protecting the community and workers. We present these findings in detail in the following section.

Before the Crisis, an Expected Crisis, and Extension Toward Stakeholder Leadership

Before the COVID-19 pandemic hit TIH, it caused devastation in developed countries. Some experts forecasted a bigger crisis for developing countries; some others, however, thought the COVID-19 crisis would not be all that damaging. This contradictory information brought an ethical dilemma for hospital leadership, as explained by one participant:

> When students were stopped from traveling outside China, we sensed that this crisis could hit us. I think [the] Western world reacted lately[and] ignored signals…which created bigger crises or multiple crises. They could have paid more attention to signals and prepared well. Our choice to listen to experts was the right choice because it gave us time to prepare (Founder, 1).

Understanding Expected Crisis

As the crisis unfolded in developed countries where well-equipped hospitals with the capacity to deal with the crisis began to collapse, the leadership at TIH started discussing and preparing. The data of this study revealed that at TIH, the top leadership expected the crisis because of their professional background and general understanding of how the virus spread. Thus, they were fearful, as one founder explained:

> We were afraid that the next thing would be, we'll have a patient at the doorsteps which we won't know…what to do [with].
>
> When we asked participants how expected crises are different from other crises, they shared that unexpected crises (such as earthquakes, an increase in emergency patients due to terrorist attacks, or a factory fire) are unforecastable; hence, management cannot make plans to deal with such crises. However, expected crisis are forecastable, as highlighted in excerpts from interviews:
>
> After seeing the situation of China and Italy, we expected that COVID-19 [would] be a disaster for Pakistan. So, when the pandemic happened, we managed to collect the top leadership as a huddle and decided that we [were] going to start preparing for things to happen (Founder 1).

Though expected crises are forecastable, certain characteristics of these crises make them precarious:

> In the initial stages of COVID, there was a fear that people[were] going to die, and the personal protective equipment was also deficient…The fear was that …not only the patient [would]die, but the physician [would] also not survive, but that was the main challenge (Counselor and Psychologist).
>
> As hospitals in developed countries have not had resources, …we are panicked that Indus Hospital [will] run out of resources and virus will spread among staff members (Nurse in Emergency Department).
>
> The crisis is expected, but it is new; therefore ambiguity is there, so no one on the earth knows how to manage it (Founder 3).
>
> Another characteristic of expected crises participants highlighted is that those crises can be averted, or their negative effects can be reduced by taking preventive measures. An anesthesiologist explained this dimension of expected crises:
>
> We expected that once one patient is diagnosed in Pakistan, if the government does not ensure lockdown or take precautionary measures, within two or three weeks, we will have a huge jump in the number of patients that hospitals won't be able to manage.

Another physician explained that in expected crises, if the person responsible for managing the crisis does not take precautionary measures, they can contribute to the crisis:

> We, as doctors, know the COVID-19 crisis [can] be dangerous, but if we do this and this, it can be managed. On the other hand, if we ignore [the crisis] and tell people to be calm, we are intentionally playing [a] role in creating the crisis (Consultant, internal medicine).

We also found that initially private hospitals that did not play a role in managing the crisis had some role in perpetuating it. In the beginning, other private hospitals did not admit COVID-19 patients; hence, the burden on TIH and other hospitals increased. Meanwhile, some people were also not taking precautionary measures and frequently violated lockdown policies, which led to the virus spreading faster and further exacerbated the crisis.

Ethical Dilemmas and the Role of Organizational Purpose

TIH leadership ability to forecast the crisis posed ethical dilemmas. A crisis was coming, and they had time to prepare, but they were afraid. They lacked knowledge and resources, and fear began causing problems for the staff. With unexpected crises, ethical dilemmas arise following the crises; however, with this expected COVID-19 crisis, forecasting, the ability to take precautions, fear, and a lack of clarity gave rise to multiple ethical dilemmas even before the crisis occurred.

The first dilemma was whether to open the hospital doors to the community or protect employees (see Fig. 1) by closing them (as many private hospitals in Pakistan did). Both choices were problematic, but focusing on the hospital's overall purpose helped TIH navigate the dilemma, as elaborated by one of the founders, who explained how purpose helped TIH make a choice:

> In the first meeting, it was debated whether Indus deals with the COVID-19 crisis or not. I made it clear whenever there is a challenge and whenever there is a need. And everybody agrees with me that Indus hospital has never backed down… Whatever the risk, whatever the subsequent consequences. We have stepped in…we have taken lead. Of course, [our] primary aim is to protect us, our staff, [and] we will not subject them to an unnecessary risk… We are not a commercial organization. We are not here to make money but our purpose is to serve people.

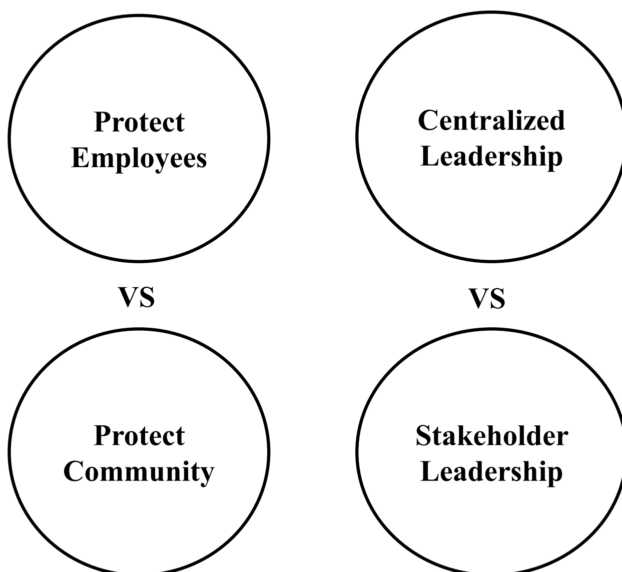

Fig. 1 Graphical description of ethical dilemmas

TIH's leaders assured doctors that they would protect them but would also stick to the hospital's purpose. Top management's decision to stick with TIH's purpose influenced other employees, one participant replied as follows:

> Yes, starting I was very fearful… but [we remembered] our oath and then we realize[d] that purpose is key and we cannot stay away from the patients, so I worked in [the] COVID-19 ward.

Once the hospital made this choice, the next ethical dilemma (see Fig. 1) was who would take on the leadership role. Should one leader lead or delegate leadership to others? Both choices were difficult. We found that one challenge was taking the decision-making role away from senior management members and giving more freedom to the doctors who were risking their lives to help patients:

> The COO [chief operating officer] was side-lined... It is a physician-driven exercise; hence, largely the physicians in various roles have taken [the lead] (Founder 2).

As the number of COVID-19 cases increased in Pakistan, decision-making authority was given to multiple leaders. In the old setup, the CEO and COO made key decisions, but in the crisis, all the decisions related to COVID-19 would be taken by new people. The managing director elaborated:

> The first step I took after discussion with senior management was the hospital formed two committees of several leaders, named COVID Lead Group (CLG) and COVID Task Force (CTF).
>
> When asked why that was done, he explained:
>
> Nobody likes giving up power…but I believe purpose influenced me to give up the position…I gave freedom to new leaders; my purpose was to help patients and reduce the negative impact of the crisis.

Adopting a Stakeholder Leadership Approach to Manage Expected Crises

We found that TIH discussed all the strategic decisions, which committees assigned and then implemented. So there was no single leader or central decision-making system. However, a relationship-based leadership approach

was followed by assigning the task to multiple leaders, as explained by the supply chain director:

> In the lead group, we had representation from all departments. We [had] representatives from infectious disease, medicine, a representative from nursing, initially supply chain, and even [the] mechanical and plumbing department. We all discussed, formulated policy, took decisions together.

Moreover, we also found evidence for the relationship and coordination of leadership in the secondary data; for example, one email sent to all faculty members stated that three doctors would work together:

> Date: 19th March-2020, Subject - update for faculty | COVID-19 | activities at the Indus Hospital, Karachi
> Respected Faculty,
> [Names of three doctors] These three will coordinate with each other and ensure posting of available faculty and residents in various COVID-19 related activities as per need, be it COVID unit or ER or any other facility.

When we inquired why these experts were included at TIH, senior management members said they believed they needed these experts because of the nature of the disease and the doctors' experience in other crises. When the managing director noticed that some people had concerns, he sent the following email to all employees:

> Dear colleagues, please remember…while managing such disasters. It's all about teamwork and does not relate to being a senior or junior. Any non-compliance to decisions may lead to further disasters.

Enfranchising Multiple Leaders by Giving Power and Control

At TIH, the CEO and board members believed that they needed unity to make and execute decisions as quickly as the situation demanded, and this speed seemed impossible if only one person had the power to make decisions. As elaborated by a senior and new leader:

> [The] CEO entrusted the responsibility to us. We were the doctors … So us, we took all the decisions about the COVID unit, about the how to what medicines to get for it, approve them, what equipment is needed, how the unit should remain…
> Basically my role in COVID is as a leader, I have told you my leadership style, I do consultation, I delegate tasks and give power [away], and I monitor (Executive Director Medical Services)

This distribution of power empowered doctors who did not normally lead to have authority, while traditional leaders (CEOs and executive directors) who had power in the past became less critically important to TIH's shared goal. TIH also created the CLG (a strategic group), which included senior management and the founders, along with junior people; experts, however, were given decision-making power. The following example illustrates the role of experts in decision-making meetings:

> The decision process was that if it was a medical decision, the infectious disease people's decision was taken as final after discussion; if it was a supply chain–related problem, the supply chain person's decision was taken as final. If it is an HR problem, the HR person's decision is taken as final (Founder 4).

Facilitation by being Part of the Decision-Making Group

To facilitate and ensure meetings functioned effectively, senior leadership and the founders believed they needed to be part of the regular decision-making meetings. As one founder elaborated:

> Our main role was that we didn't want anybody to get into an argument and get stuck so we were part of meetings to facilitate smooth conduct (Founder, 3)

In the early days of the pandemic, ending meetings on time and avoiding unnecessary discussions were nearly impossible for TIH's staff. As the founders highlight, they facilitated with leaders in determining better ways to control conflicts and avoid unnecessary arguments:

> We were basically part of meetings just to assist the whole group and get them together (Founder 4).
> In this crisis, my role has been the man who is sort of holding things together and you know, consoling with people and sort of putting them in the right place and letting them do the right things (Founder 2).

Sharing Operational Work and Reciprocal Influence

Our data analysis revealed that TIH's senior leaders involved themselves in operational work. Thus, another distinctive common characteristic TIH practiced during the crisis was sharing operational work with other team members. An anesthesiologist noted,

> I saw the most senior doctor today in the operation theatre.

Secondary data supported this claim, for example, in the CLG's meeting minutes. We found that one of the founders was assigned operational work, as evidenced in the following meeting agenda for March 28, 2020, under the subheading "COVID unit admissions, task, and responsible person."

> MEP [Mechanical, Electrical, and Plumbing engineering] activities to accommodate COVID-19-positive surgeries [Founder 2]. MEP activities to accommodate COVID-positive OB-GYN admissions [Head of Emergency Department].

Senior management knew that the hospital was a place with an increased probability of infection and that COVID-19 could cause serious issues for older people. Despite these risks, senior management attended hospital meetings, helped set up wards, and even worked in the wards. Management taking the lead in operational work and working with staff was useful in influencing other workers; one nurse in a COVID-19 ward elaborated on the impact of these actions:

> I can call my COVID-19 ward lead anytime, and she replies quickly. And I also see my CEO and director working; this influences me not to give up.

A senior director provided an example of how this approach impacted employees and influenced an overall increase in resources:

> People who work in Indus are the people who want to work hard. When they see us working, they work. They're not there to pass eight hours a day. They want to work; the majority of the people in Indus work more than eight hours a day (Executive Director Medical Services).

Top management's willingness to share power and delegate responsibility while facilitating management in collective decisions contributed to keeping a balance between empowerment and control. In addition, the founders' and senior management's participation in the operational work at TIH influenced other hospital leaders, which contributed to the aggregation of resources. Moreover, we noticed that the work of new leaders during the crisis influenced senior management; one reason senior management bestowed power on other leaders and shared operational work with employees was because they were influenced by the new leaders, as is evident in the following founder's quote:

> The few people who were very much leaders in this hospital before the crisis, they were not on the scene, and they [leaders during the crisis] are new leaders; in my eyes, they are the future leaders because they've proven themselves. I think by allowing them to do things and giving them freedom and support, they've really shown their beauty (Founder 1).

This sentiment of senior leadership reflects the positive influence of new leadership. Subsequently, it is not always leaders who influence; other team members can also influence leadership by carrying out assigned tasks. And through operational work, leadership can influence team members. This reciprocal relationship between leaders (senior leaders doing operational work and giving power to new leaders, who in turn influence senior leadership) helped TIH address the ethical dilemma of who should lead in the crisis as well as address the myth that multiple leaders, if involved in decision-making, would slow decision-making. Centralized leadership is usually preferred in crisis situations due to its ability to foster effective communication and fast decision-making; however, TIH leadership believed that if multiple leaders were involved, they would take responsibility in ways that would lead to fast decision-making. One medical doctor explained:

> From the beginning, members were meeting each day to discuss things in detail and prepare a plan…. Employees' rota [rotation] was extended from 8 to 12-hour shifts. Emergency room rota model was implemented in [the] corona ward…These actions of each employee ensured fast functioning of the hospital (Consultant, Internal Medicine Department, and Corona Task Force member).

Another employee explained the benefit of adopting a stakeholder leadership approach:

> These flowcharts are made by multiple leaders and [those] who have to run this place because their ownership is critical… We together, simply polish, but [the] actual crux of it has to come from them. So that is always the Indus approach in crisis situations (Medical Director).

How Considering the Crisis as Expected and Stakeholder Leadership Impacted the Community, Co-Leaders, and Workers

It was difficult to assess TIH's performance during the pandemic. COVID-19 was a new disease, and its treatment varied from patient to patient. For this study, performance in a crisis situation is assessed along two dimensions: giving health care access to patients and ensuring the well-being of health workers (peer leaders).

The Well-being of the Community

A progress report noted that TIH had 'treated more than 1800 seriously ill patients at zero cost.' We collected evidence from patients who shared his experience on social media as follows:

> I am an employee in a private hospital. I know the condition of health services and cost. Honestly, I got the best care in the hospital at zero cost. I was allowed to talk to my family via Skype (video message on social media by patient who had recovered from COVID-19).

The Well-being of Co-Leaders and Workers

Many hospitals fired employees or reduced their salaries during the pandemic. We found that at TIH, no one was fired and salaries were not reduced. On the contrary, a gratitude allowance was given to the staff who worked in COVID-19 wards. In addition, the hospital established a psychological support center for its staff. Moreover, TIH provided PPE to all its staff members, juniors, and seniors, as explained by the nursing staff and residents:

> The hospital had one stock available, but it ordered PPEs (internal report supply chain management [SCM] department).
> You won't believe but we were given PPEs, psychological support, and place to live inside the hospital (Nurse, COVID-19 Ward).

We also relied on secondary data such as government reports, progress reports submitted to the WHO, reports of the Sindh medical services, email communication records, and websites. The analysis of these secondary data shows that the hospital managed to protect its employees' well-being amid the crisis. This is demonstrated by one employee who elaborated the following:

> Hospital didn't fire anyone, didn't cut salaries, though elective units were close[d] for two months, however, [the hospital] gave [a] bonus to people working in COVID-19 ward.

Moreover, this hospital was leading in the Pakistani government's COVID-19 response initiatives. The overall impact is reflected in a WHO report, which shows that despite being an under-resourced and highly populated country, Pakistan performed better than its immediate neighbors and several other lower-middle-income countries (Zaidi & Hussain, 2022). The same report highlights that a multi-country analysis of the COVID-19 response ranked Pakistan's performance relatively favorably at eighth out of 35 countries in 2020 (Zaidi & Hussain, 2022). Economists also ranked Pakistan number 3 after Hongkong and New Zealand with a score of 84% in returning to normalcy quickly (economistgroup.com, 2021).

Discussion

Our study suggests that some crises are more expected (predictable), whereas others are unexpected or unpredictable, and these two scenarios give rise to different ethical dilemmas. In Fig. 2, we present the graphical elaboration of the dimensions of expected crises.

Figure 3 is the framework of the crisis' evolution abstracted from our case, outlining the dimensions of expected crises and the resulting different ethical dilemmas that pushed TIH to adopt a stakeholder leadership approach to achieve its purpose of giving health care to those unable to afford it.

We found that the expected nature of the crisis posed a challenge to leadership. Those in power could trust experts'

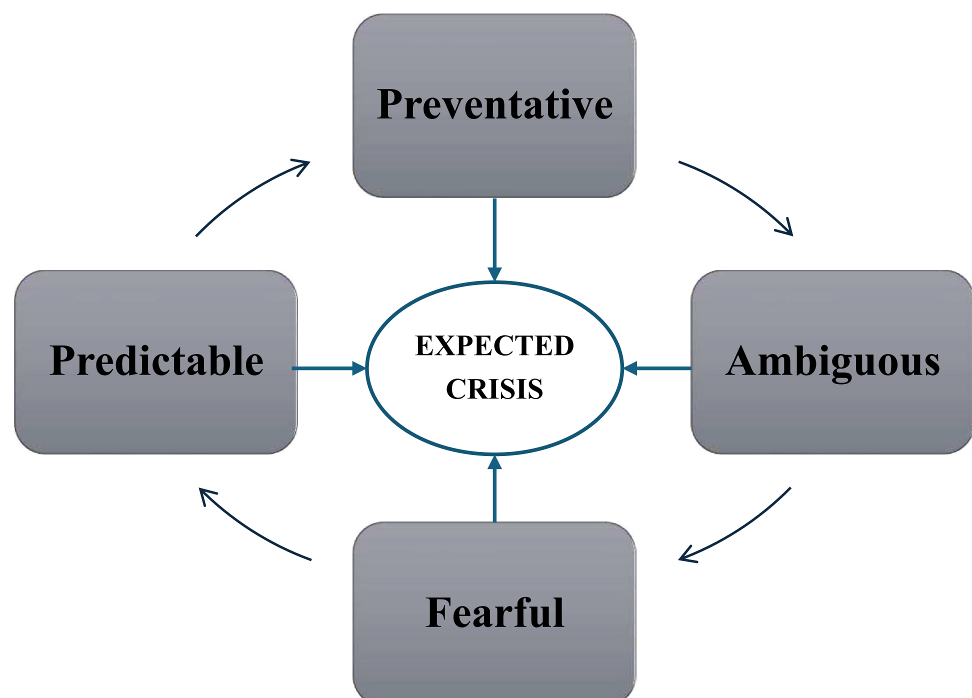

Fig. 2 Dimensions of expected crisis

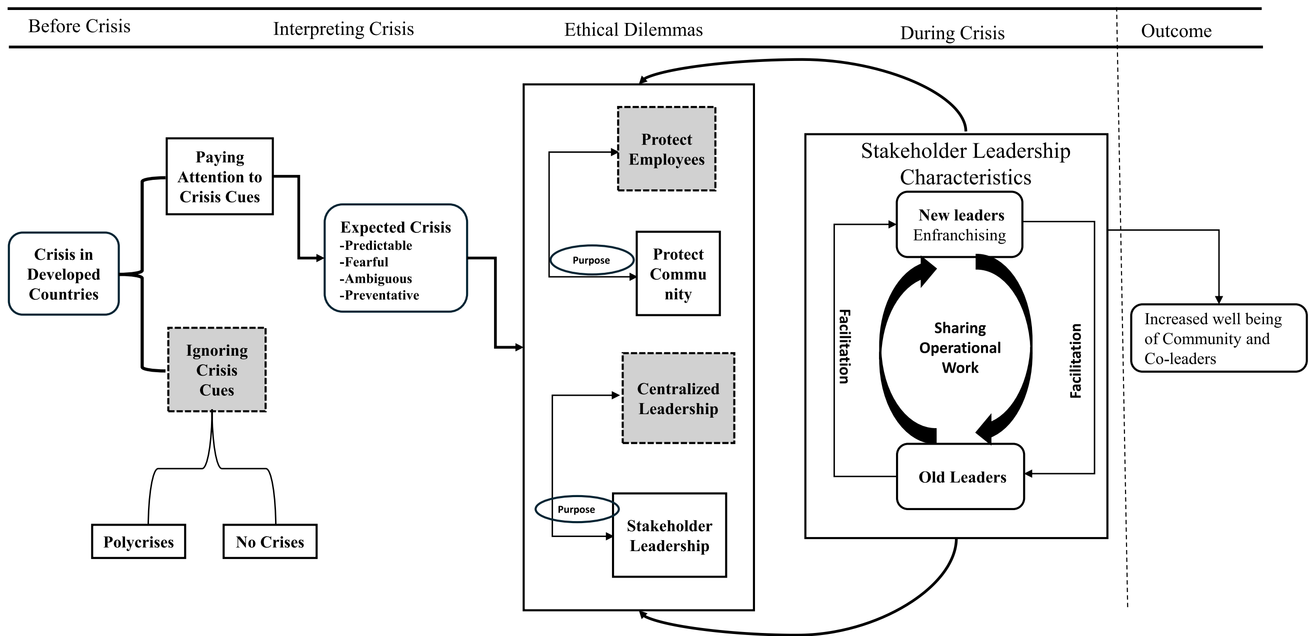

Fig. 3 Process Framework for Interpreting and Navigating Expected Crises

warnings and pay attention to the signals of the upcoming crisis, or they could just wait until the crisis hit them. Unfortunately, warnings about the forthcoming COVID-19 crisis were largely ignored, even after the disease caused disasters in developed countries. In other words, purposeful inaction and lack of a precautionary approach led to COVID-19 becoming a polycrisis. People and organizations who ignored these signals were not only hit by the crisis, but also bore the cascading effects thereof, creating a polycrisis. For instance, hospitals that ignored COVID-19 quickly ran out of resources and lost the lives of their health workers.

If organizations pay attention to signals that a crisis is coming, the next step is interpreting that crisis. An expected crisis is an event that can be predictable and preventable but capable of creating fear. Predictability pushes fear because actors who know about the crisis and will be managing the crisis. These elements of an expected crisis pose major ethical dilemmas to organizational leadership, putting leaders in moral dilemmas where all available options have moral justifications, but taking all actions is impossible (Selart & Johansen, 2011).

In this study, the first ethical dilemma was regarding opening or closing the hospital (to stay open and deal with the crisis or close TIH's operations). Another ethical dilemma was a question about leadership: Who should lead the organization (Centralized leadership or Stakeholder leadership) during an expected crisis to ensure fast and effective decision-making? To make a choice between these two options, TIH's purpose (i.e., "Why do we as an organization exist?") had a crucial role. Organization used purpose as a guiding principle for making a choice when confronted with ethical dilemmas. It chose the option that was more strongly aligned with its purpose.

Our findings further highlight three interrelated characteristics of stakeholder leadership: enfranchising new leaders, sharing operational work, and facilitation. In our case, people who were not leaders before the crisis were enfranchised with leadership roles, and people with previous leadership roles assumed the role of facilitators. Enfranchising new leaders empowered them to make decisions, and facilitation helped old leaders keep control. A form of stakeholder leadership arose wherein individuals were mutually influential and helping each other; consequently, the leadership process became reciprocal (Pearce et al., 2023). This became a two-way process—old leaders giving stakes to new leaders in decision-making and taking a stake in the operational work of other leaders. This relationship is often useful in expected crises (i.e., disease outbreaks and humanitarian disasters) where operational work is dangerous but crucial for aggregating resources. When senior management gives power to new leaders while participating in operational work, other employees feel inspired or compelled to work in crisis situations that are dangerous and life-threatening. Doing operational work can also be useful in maintaining overall control because leaders have greater firsthand knowledge of the situation. It is also possible that senior leaders did operational work because they felt empowered or influenced by new leaders. Thus, the relationship between different leaders at TIH became reciprocal, and the leaders became mutually dependent (as Fig. 1 depicts). This study's findings suggest

the adoption of stakeholder leadership is crucial in uniting multiple leaders, managing an expected crisis. Doing so results in the well-being of the community, of co-leaders, and of workers.

Theoretical Contributions

Our findings on the understanding of expected crises, resulting ethical dilemmas, and the dynamics of stakeholder leadership contribute to literature in multiple ways. In the following section, we articulate our arguments' theoretical underpinnings and highlight the novelty of our findings to show how our findings differ from and challenge current assumptions in the crisis management literature.

First, one contribution of this study is the understanding of crises. Considering a crisis as an unexpected event and ignoring experts' signals can create massive trouble for individuals and organizations, especially now, when a large number of crises are recurring and common. For instance, floods, fires, hurricanes, immigration and displacement, infectious diseases, and financial crises. These crises can be better classified as expected events. This is contrary to prior literature that considers unexpectedness a core element of crisis events (Bundy et al., 2017; Hällgren et al., 2018). We illustrate four dimensions of expected crises: They are predictable, preventable, ambiguous due to associated fear, and result in ethical dilemmas. This distinction between expected and unexpected crisis is important because considering expected crises, unexpected means purposefully ignoring the oncoming crises and helping extend their overall magnitude. Considering all crises as unexpected events can hinder the preparation needed for managing and opens a route to temporary escape from ethical dilemmas and challenges of crises.

For instance, many people ignore or deny the upcoming global warming-induced climate crisis. Despite experts' warnings and fears of an impending climate crisis, these people continue to practice anti-environmental policies and actions because they are firm believers that a climate crisis is not expected; as with COVID-19, these actions can further enhance the overall intensity of the crisis, and potentially even create a polycrisis.[2]

Second, our study suggests that revisiting an organization's purpose can guide organizations in navigating ethical dilemmas during an expected crisis. In an expected crisis, the first big ethical challenge is to be open about either managing the crisis or closing operations. Strategy literature suggests that closing operations or an exit strategy (discontinuation of business activities) amid a crisis is a viable option (Argyres et al., 2015). In this study, TIH made a choice to remain open because of that choice's alignment with the hospital's organizational purpose. In an expected crisis, the crisis' predicted impacts can provoke fear; hence, actors who should be managing a crisis can instead become focused on self-protection. For example, in a study on the Ebola crisis, Wright and colleagues found that amid fear of crisis, managers and leaders became scared, prompting the closure of crisis-response facilities to avoid personal harm (Wright et al., 2021). Similarly, many private hospitals in underdeveloped countries closed their doors to COVID-19 patients to save their doctors and staff (Menghwar, 2021). If an organization wants to open up and face the crisis, then organizational purpose becomes crucial. It aligned with TIH's purpose—the reason TIH exists—to empower people to deal with the COVID-19 crisis and to have TIH's staff risk their lives to manage the crisis. Purpose gives a sense of direction and meaning in times when the predictability of a crisis creates fear.

Another ethical dilemma in expected crises is who should lead the organization—CEO (centralized) or multiple leaders (stakeholder leadership). We found that the stakeholder leadership style works well in expected crises because it allows leaders to take responsibility and work together for a shared purpose. In conceptualizing stakeholder leadership, we emphasize three characteristics: enfranchising new leaders, sharing in operational work, and facilitation.

Leadership scholars have focused on a leader's characteristics, such as their charisma or personality (Collins et al., 2022; Raelin, 2023), and highlighted that the charisma of a leader and centralized decision-making are helpful in effectively managing a crisis (Wu et al., 2021). However, our findings underscore the importance of multiple leaders and conducting operational work to influence other people in a crisis situation. Our study indicates that a leader performing operational work is more effective than charisma alone and that it can help organizations build strong relationships within leadership and survive during crises. For example, COVID-19 is a deadly disease and more dangerous for older people (senior leadership), yet despite this threat, TIH's senior leadership worked in COVID-19 wards. These actions influenced other people to work diligently in the wards despite the risk of death. This clarifies that in an expected crisis, one way to influence a team is by working alongside that team. In other words, the leader's charisma is not necessarily required. Although a leader's qualities include articulating a vision and showing determination, communication may be helpful during a crisis (James et al., 2011). Our study highlights the importance of leaders doing operational work in inspiring fellow leaders and subordinates by working together. This confirms that the charisma of a single personality is not the only decisive characteristic helpful in

[2] See the work of Prasad (2019) on Denying Anthropogenic Climate Change: Or, How Our Rejection of Objective Reality Gave Intellectual Legitimacy to Fake News.

navigating crisis situations. This was echoed by Halverson et al. (2004) in their experimental study, which found that charismatic leaders in crisis conditions actually experienced a decrease in charismatic behavior.

Another characteristic of leadership at TIH was giving power to new leaders while acting as facilitators, ensuring an effective process of discussion to reach decisions. Prior research argues that the health care context creates a paradox for distributed leadership because power is concentrated around professional experts (Currie and Lockett, 2011). In this study, we found ample evidence that shows that leaders, who in this case were professional senior doctors, gave power to other doctors and other professionals in order to ensure the enactment of leadership, with old leaders acting as facilitators. This influenced new leaders to work during the crisis and not to indulge in power dynamics.

Managerial Implications

This study suggests practical actions that leaders can take to navigate a crisis, specifically to empower new leaders and manage ethical dilemmas.

Embrace Expected Crises

Managers and leaders can exacerbate a crisis by ignoring warnings and showing avoidance in taking precautionary measures. Our study suggests that it is crucial to take future crises into consideration. This point seems obvious, but there are many crises which are largely ignored. As noted, one such expected crisis is the climate crisis, the chances of which are increasing due to global warming. Pew Research Center reports that "as the Earth's temperature continues to rise, fueling more intense storms and extreme weather, scientists are calling for immediate action to address climate change. However, climate change remains a lower priority for some Americans, and a subset of the public rejects that it's happening at all" (Pasquini et al., 2023, p.4). Despite warnings, managers, policymakers, and people broadly are dismissing the havoc that the climate crisis can cause.

Ignoring warnings can push companies into polycrises. One such example is the case of Boeing. The CEO of Boeing was unable to forecast a crisis because of the compromises they made on safety measurements in the organization (Hood, 2024). Despite warnings from employees, Boeing's CEOs did not expect a crisis; instead, the company forced employees to compromise on safety features and did not supply the required resources to ensure safety. This led to dangerous incidents such as a door coming off a Boeing 737 Max 9 jet during an Alaska Airlines flight. Another example of missed warnings, just four years after the COVID-19 crisis, is Mpox, a viral disease that became a global emergency in 2024, which scientists believe could have been avoided had warnings not been missed or ignored (Furlong et al., 2024).

For understanding a crisis, managers should consider the dynamics of expected crisis situations. In expected crisis scenarios, there can be two schools of thought within an organization: one that expects a crisis and one that dismisses a crisis. Ignorance or denial of warning signs increases the chances and severity of a crisis. For example, when doctors realized how dangerous COVID-19 was, they wanted a societal lockdown. However, many policymakers were against a lockdown and ignored these doctors; thus, the COVID-19 crisis resulted in many more deaths than it otherwise might have. Ignoring expected crises like these policymakers did can result in complex polycrises and complicate decision-making during crises. Considering the COVID-19 crisis, the examples discussed above, and our findings overall, we suggest that attentive scanning for crisis cues combined with a mindset that allows for proactively addressing a potentially unexpected crisis is a better option than doing nothing. "Doing nothing" might develop into polycrises with even more severe consequences.

Emphasize Organizational Purpose to Resolve Ethical Dilemmas

Evaluating the organization's purpose is a powerful tool for making choices during ethical dilemmas and crisis situations. Our study shows that managers and practitioners can use purpose as a tool for decision-making, for example, by asking, "Why does this organization exist?" or "What is the purpose of an individual's life?" Understanding purpose has a central role in leaders making good choices during ethical dilemmas, where multiple options seem reasonable. In such dilemmas, the most valuable option is that which serves the broader purpose of the organization or individual. Contrarily, leaders of organizations with narrow purposes or no declared purpose at all will make self-serving choices when confronted with ethical dilemmas during a crisis—choices that could lead to self-destruction. While most organizations declare their purpose, it is easily pushed into the background of daily operations. In contrast, our study suggests it is beneficial to activate the purpose lens to drive ethical decision-making in crisis situations.

Adopt Stakeholder Leadership Instead of Centralized Leadership

For leadership, this research underscores the importance of a stakeholder leadership approach that consists of three main characteristics: enfranchising new leaders, facilitation to keep control, and sharing in operational work. Our findings suggest that leadership needs to shift its role from setting vision and strategic direction to managing crises by taking

the lead in operational work. In expected crisis situations, leaders need to be the first to engage in operational work that can inspire other workers. Leadership should not adhere to its traditional role of strategic planning and decision-making during crisis; Instead, leadership must hand over this role to experts and act as facilitators. Doing so will bolster employees' confidence and ensure fast, effective communication, which is vital in managing crises. These characteristics of stakeholder leadership are also helpful in uniting team members, thus enabling organizations to navigate uncertain times.

Conclusion and Areas for Future Research

By challenging the assumption that crises are not unexpected but rather expected events, we have explained that seemingly rare and extreme crises are actually common and expected. Thus, they can be managed before their occurrence. However, more research is needed to understand how expected crises can be averted. Sometimes, an unexpected crisis later transitions to the expected crisis. For example, for China, where the pandemic began, it can reasonably be said that some crisis cues were not taken as seriously as they should have been. Chinese doctors who first reported the outbreak gave warnings and enacted whatever precautions were possible to avoid a crisis (for details, see the work of Li et al., 2020), but the overall crisis was difficult to forecast. Similarly, in Italy, the crisis hit with an intensity that was difficult to forecast. But, in general, the Chinese and Italian cases transformed the pandemic from an unexpected crisis into an expected one for many parts of the Western world in line with experts' warnings. Therefore, more research is needed to understand such a transition from unexpected to expected crisis.

The role of leadership cannot be underestimated in interpreting as well as managing the crises. Our study has highlighted three characteristics of stakeholder leadership, but our findings are derived from a single case study and so must be transferred with care. In the future, scholars can test these findings in crises involving financial corruption, employee negligence, or similar settings. Insights from this study are based on the COVID-19 crisis, which affected all stakeholders in the organization. More research is needed on how stakeholders respond to an organization's approach in other extreme crises. Stakeholder leadership is an understudied topic, and more research is needed to understand how communication among multiple leaders creates tensions and worsens crisis management. We have focused on how stakeholder leadership manages other leaders during a crisis; more research on how this leadership style can manage other stakeholders during a crisis would be important in understanding its benefits and potential problems. For example, how leadership styles change over time and might vary before, during, and after a crisis could be an interesting avenue to explore. Recently, organizational scholars have started focusing on various inequalities, including caste inequality (Bapuji et al., 2020). Research on how stakeholder leadership can reduce caste inequality within organizations by giving low caste employees access to resources or support would be useful in understanding this critical issue. More research is needed to understand how stakeholder leadership is effective or ineffective in engaging with marginalized communities during a crisis (Freeman & Menghwar, 2024). Another question that demands research is, which set of capabilities an organization needs to engage with marginalized communities (Menghwar & Daood, 2018)?.

Serendipity scholars would consider crises as serendipitous events because the traditional understanding of crisis has an element of surprise, one of the necessary conditions of serendipity, but advocates of the serendipity school of thought would also emphasize the role of purposeful action (Busch, 2024). In our study, we found that purposeful inaction or ignorance led to an expected crisis. Some could argue that purposeful inaction is an action; for instance, doctors who were expecting a crisis but remained silent contributed to the crisis. The boundaries between our understanding of expected crises and serendipitous events, however, are ambiguous. Therefore, we ask for more empirical research on understanding the boundary conditions of expected crises, namely, when a crisis is due to purposeful inaction and human agency, such as how ignoring or missing the warning signs of climate change leads to frequent heat waves, storms, and other crises. We hope to inspire more research at the intersection of these two concepts, expected crises and serendipitous events.

A final theme that demands more empirical research is how ignoring signals of expected crises leads to polycrises. For instance, many hospitals around the world suffered a polycrisis during COVID-19, though polycrises can arise in less extreme situations, too; as previously described, Boeing's unwillingness to address a variety of safety and quality assurance concerns led to a series of crises affecting the company, brand, and even air travel. Research on cases like these would generate highly useful knowledge and further advance crisis management theories.

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